

Introduction

As one of the nation's most rural states, North Dakota (ND) faces a unique set of circumstances in the provision of quality human services to its most vulnerable citizens. The low population and relatively small industry result in a small tax base. This, combined with a fiscally conservative state government, make human services' budgets lean. When compounded by a sparse population spread over a large geography, where weather and long distances prohibit or disrupt services, individualized human services delivery is problematic. Despite these challenges, North Dakotans are a resilient and resourceful people. Often viewed as rugged individualists, they care deeply about family, individual choice, and opportunity. Living on their own, in their home communities, near family members is vitally important.

Beginning in the 1960s, the State Hospital, ND's institution for people with mental illness, began a significant reduction in its population. This came about because of the establishment of regional human service centers, where community mental health centers and area social service centers were co-located. The State Hospital also established a transitional living facility to prepare individuals for movement to their home communities. Finally, pharmacological advancements have allowed individuals greater independence.

ND also went through a massive de-institutionalization process where nearly 2,000 people with developmental disabilities were moved from two institutional settings (Grafton State School and San Haven) into communities. Further, state funding for community-based long-term options for the elderly has increased. Over the past 10 years, ND's funding for non-nursing home care has increased by over 50%. These efforts show a good start for movement of all systems of care toward the community.

But ND needs assistance to truly transform its systems toward community-based services for persons with chronic care needs (CCN), those with mental illness (MI), and persons with CCN and MI who are adversely impacted by socio-economic factors and unemployment. ND is just beginning a complete revision of its Medicaid management information systems (MMIS). Because of its high costs, important add-on features that are more client-oriented may not be included in the new system. ND presently has no comprehensive clearinghouse of information on long-term care options for people with disabilities or the elderly, and the ability to assist those with individualized questions is severely limited by geography and resources. Comprehensive data are not available on all the private funding or volunteer options that might be advantageous for consumers. In addition, there have been insufficient marketing and advertising efforts to make citizens aware of these options. Finally, human services systems, especially ND's long-term support service programs, need to connect more closely with public and private housing associations that can support community-based living options.

ND's System Readiness Assessment (SRA) data suggest the state needs assistance in moving from a mid-range transformation level to a higher status. In particular, ND needs to develop a one-stop system; catalog and disseminate additional options for funding community-based supports; improve our technology capability to increase awareness, share information and provide technical assistance; and establish firm linkages between community housing programs and the human service systems.

Part 1: System Readiness Assessment

1. Level of support for system transformation.

Level of support. There is great support for the ND Systems Transformation Grant from all levels of state leadership. Governor John Hoeven has stated his current support (see Appendix A, Hoeven letter) for the project, and his commitment to improving choice and access to services for the elderly and people with disabilities, (see Appendix B, press release). Currently the Legal Counsel to the Governor sits on the ND Real Choice Rebalancing Grant's committees. Since 2005, one of Governor Hoeven's top priorities is the Quality of Life Initiative, which focuses on taking care of people. This initiative includes support for increasing funding for long-term care providers and home and community-based services. Legislative officials have participated in many of the current Real Choice Rebalancing Grant's information and discussion sessions and committee meetings, and they support the concepts of the grant. There is active participation from various legislators in support of systems change initiatives or support transformations.

The Executive Director of the Department of Human Services, Carol K. Olson, and all department managers strongly support continued development of quality community-based services through this project (see Olson cover letter). The ND Budget Director, Pam Sharp, and the State Medicaid Director, Marget Anderson, both offer their support and encouragement for the Systems Transformation Project as well (see Appendix C, Sharp and Anderson letters of support). ND's Governor-appointed Olmstead Commission has provided leadership and recommendations for previously funded Real Choice Systems Change Grants and is currently developing an Olmstead plan for ND that will be used in collaboration with the Systems Transformation Grant (STG) to continue implementation of the Olmstead decision in ND. This commission also endorses the work of this project (Appendix D, Olmstead Commission letter of support).

Reorganization. Presently, we do not see any reorganizations of ND programs or departments that would impact leadership. This project will be under the auspices of the ND DHS, Executive Director. Ms. Olson has recently reorganized the ND DHS administrative and operational structure to more effectively handle a broader continuum of community-based and consumer-oriented programs and issues (see Appendix E, ND DHS organizational chart). The new structure allows the Executive Director and her Cabinet to devote more time for strategic planning, coordinated operations, and development of new initiatives to better position ND DHS to focus on future issues. The responsibility for all Medicaid waivers along with Home and Community-based Services (HCBS) have been concentrated within the Medical Services Division for the following reasons: 1) it will place a greater focus and awareness on HCBS and disability services as they are placed on the continuum of long-term care; 2) with the Medicaid reform process in Washington D.C. placing more emphasis on waiver-based programs, ND DHS will be pooling staff with waiver expertise (this should allow for greater depth, expertise and collaboration decision-making in one location); 3) it will allow for consolidation of waivers to be more inclusive in the populations served; and 4) it will place the responsibility and accountability in one location for better oversight and greater consistency in policy and responses to providers and clients.

Consensus level. There is consensus throughout the state for ND's systems transformation efforts. Over the past ten years, consumers, their families, advocates, and providers have impressed upon ND DHS staff, legislators and the Governor's office the importance of a coordinated and integrated infrastructure to support citizens who are in the target

populations. Many of the issues have been studied at length by constituents and the legislature to identify the problems and the need for change. However, the complications of funding, rural geography, and service accessibility have resulted in some disagreements about how to develop such a system, and more importantly, how to operate it on a long-term basis. ND sees this project as an opportunity to build on this consensus and develop a vision, mission, and plan to support individuals with chronic care needs, mental illness, and people with these conditions who are adversely impacted by socioeconomic and unemployment situations.

2. Interactive involvement and support of consumer/ family / participant groups, provider associations, state government agencies, private organizations, and other pertinent entities.

Interactive involvement and support. There is broad support for a systems transformation process in ND. This support ranges from favorable commentary by individuals, consumers with disabilities and their families, and various state and regional committees. Each is briefly described here.

Consumer and family member support. The Real Choice Rebalancing (RCR) grant stakeholder committee has identified issues related to this grant's goals, and supports this proposal. Further, stakeholders, consumers and family members have provided commentary that supports the main ideas behind this proposal.

Committee support. ND DHS has coordinated a number of stakeholder and steering committees over the past five years. These groups have heartily endorsed the concepts behind the STG. For example, in January and February of 2006, the ND DHS held statewide public stakeholder meetings with regional ND DHS staff, clients, advocates, providers and the public to gather input for use in the development of ND DHS's strategic plan and the 2007-2009 ND DHS Budget. The executive director of ND DHS and division directors attended these meetings to receive stakeholder input first hand. This process is scheduled every two years to ensure that consumers, family members, and regional providers are able to give input about the delivery of services. At these meetings participants shared their concerns about ND's ability to meet the needs of the aging population and individuals with physical disabilities, homelessness, shortage of family foster care homes and access to other appropriate placements (See Appendix F, 2006 ND DHS Public Stakeholder Meeting Summary). The stakeholder meeting summary indicates that participants overwhelmingly supported the idea of increased access to community services.

Also in 2006, ND DHS-Aging Services Division and Medical Services Division held statewide input hearings. Consumers, providers, agencies, and the general public were invited to give input to be used for development of ND's four year plan on aging. This plan is required by *Older Americans Act* funding and provided an opportunity to secure input regarding HCBS.

ND's RCR Grant has gathered substantial input from consumers, family members, and providers on the concept of a one stop center or single point of entry for long-term care services and increased access to home and community-based support services. This input has been obtained through its steering committee and stakeholder committee meetings, as well as through regional focus groups. These committees and focus groups are tied together by the common themes of systems change, improved access to a broader array of long-term care services, and balanced funding to support consumer options (see Appendix G, RCR stakeholder meeting summary and Appendix H, focus group summary).

In 2000, Executive Director of the ND DHS, appointed an internal workgroup to review the Olmstead Decision and make recommendations on further action. This group consisted of representation from the Divisions of Aging Services, Children and Family Services, Disability

Services – Developmental Disabilities Unit, and Mental Health and Substance Abuse Services, as well as representatives from Medical Services, the ND Developmental Center, the State Hospital, the regional human service center directors, and the Legal Advisory Unit.

It was determined by the workgroup that regional information meetings needed to be held with consumers, families, advocates, and providers in the areas of mental health, aging, developmental disabilities and physical disabilities. Goals established for these meetings included:

- * Clarifying the content and nature of the Olmstead decision.
- * Updating attendees on the current status of institutional and community-based services for various populations in ND.
- * Soliciting discussion and input from attendees on areas they see as needing attention.

In August of 2000, four meetings were held via the ND Interactive Video Network (IVN). More than 200 persons attended these meetings statewide. Discussion occurred at each meeting and the workgroup answered participants' questions. In addition, attendees completed a brief survey. The surveys were gathered and analyzed by the workgroup. The efforts of the workgroup culminated in a white paper for the Executive Office of the ND DHS outlining background information, workgroup activities, and recommendations for future action. These recommendations have been used on numerous occasions, and have acknowledged the importance of home and community-based services.

ND has a State Review Team that works to resolve complex and critical issues for youth with mental illness and other complex needs. This team analyzes youth needs, examines alternative methods and funding mechanisms to effect immediate and positive change in services, and examines the impact on youth. For the past 1 ½ years, the State Review Team has examined the need for a one-stop system of services for youth with mental illness and other disabilities. Their resolve for a transformed approach is shown in information from their meetings (see Appendix I, State Review Team information).

Agreement and disagreement. Ideally, everyone would be in complete agreement on the concept of a transformed system, and all components of such a system. However, like most states, that does not occur in ND. Various constituents disagree on the levels of support and service individuals might need. For instance, ND Medicaid has a 240 hour per month limit on Personal Care Services. Some individuals and advocates do not feel this is an adequate amount of time; however, an increase in hours would result in a substantial increase in expenditures, which could force resources to be taken from other Medicaid program areas.

There is concern about how such a system might be funded, and who would be included or excluded in services. Some agencies believe that a different system might place undue burdens on them, burdens they are not prepared to bear. For example, county social services are providing case management services, and if the system is transformed, their roles may change. The county social services staff have been very active in RCR Grant's steering committee meetings and focus groups, where discussions and concerns have been raised about where they might fit into a single point of entry/one-stop system. The county staff have realized the importance of being at the table in discussions where potential systems change decisions will be made. They continue to be involved in RCR Grant steering committee discussions where many players are at the table and consensus continues to build (See Appendix J for RCR Steering Committee membership list).

The ND Long-Term Care Association (NDLTCA), which represents the nursing homes in ND, recognizes a need for increased access to community services, yet they also have strong

feelings that funding for current nursing homes must continue in order to maintain quality nursing home services. Financial incentives for nursing homes to offer services outside of their doors are limited. However, the NDLTCA continues to actively be involved in discussions as part of the RCR Grant consensus building process.

Mediation. ND has a small populous (about 640,000 people) and it is not unusual for residents and service recipients to actually know program directors and service providers on a personal basis. Thus, there is often immediate and direct communication when disagreements arise. For example, when consumers have a complaint or concern, it is not uncommon for service recipients in even the most remote counties to directly speak with the state ND DHS staff. They are able to directly air their grievances and disagreements, often resulting in an immediate response to work toward a resolution of the problem. This direct communication method also works with local service providers, agency staff, and family members. However, it is naïve to think that all issues are resolved immediately, completely and amicably. ND DHS staff have developed formal complaint procedures. ND DHS provides written notices about appeal rights to people who apply for services. Information about the ND DHS appeals process (ND Administrative Code, Chapter 75-01-03) is also located on-line in at <http://www.legis.nd.gov/information/acdata/pdf/75-01-03.pdf>. Further, applicants and recipients can file appeals or Office of Civil Rights complaints to achieve resolution.

3. Progress towards development of a shared vision for systems transformation.

Presently, ND has no comprehensive shared vision or mission statement for a systems transformation initiative. However, several programs and projects have developed pieces that will serve as the foundation for the future ND vision. For example, the RCR Grant's Steering Committee developed guiding principles for the development of a comprehensive, integrated system (Appendix K, RCR Grant guiding principles). These principles focus on expanding and communicating the continuum of care options for ND residents; supporting the Olmstead decision and the President's New Freedom Initiative; empowering individuals by expanding options, increasing information, and facilitating choice; and establishing a single point of entry for services.

This committee identified goals, objectives, and draft action steps that promote a shared vision of what might be accomplished for ND citizens. Key goals include: 1) development of a system to provide a single point of entry for continuum of care services for the elderly and people with disabilities, 2) development of a mechanism to balance state resources for continuum of care services to strengthen opportunities for choice and self-direction, and 3) development of practical and sustainable public information services for all continuum of care services in ND (see Appendix L, *Draft RCR planning document*). This information is also being used by the ND Olmstead Commission as a resource for development of ND's Olmstead Plan.

Further, as part of the ND DHS Strategic Planning process, statewide public stakeholder meetings with ND DHS staff, consumers, advocates, providers, and the public were held to gather input for use in the development of ND DHS's strategic plan and the budget for the 2007-2009 biennium. Finally, ND DHS Aging Services Division is currently developing a vision statement as part of the four-year plan. Thus, much of the environmental assessment data typically used in a strategic planning process has been recently gathered, and can readily be incorporated into the development of a vision and mission statement for this project.

4. Status of improving access to services, including development of a one-stop system.

Currently, ND does not have a one-stop system to improve access to continuum of care services. The RCR grant committees have examined ways to develop a Single Point of Entry (SPE) to address the concerns and needs of consumers of continuum of care services in ND. The committee has come to consensus on the key elements that would need to be part of any ND SPE (see Appendix L, *Draft RCR planning document*). The RCR Grant is in the process of developing a potential pilot SPE program to proposal for the 2007 legislature. However, funding such pilot projects has been a concern.

In addition to the RCR project, the newly funded University of ND Geriatric Center is developing an internet-based website to provide screening tools and access to information about continuum of care services in the Bismarck region. However, continued funding to test this site and extend it statewide would have to be found.

ND currently has informational resources available for consumers and families through the 211 telephone line, sponsored by the ND Mental Health Association. This line gives statewide information, referral, and crisis intervention service. The toll free Senior Info Line and an accompanying website provide information about services that enhance independence, assure quality of life, and meet the unique needs of seniors and people with disabilities living in ND and other states. Presently the Senior Info Line is staffed during work day hours only. However, consumers and referring entities can access the website database 24/7/365. Additional marketing efforts could enhance utilization.

In collaboration with a previous Real Choice Systems Change Grant, a corporate long-term care provider established the “Community of Care Project” that offers care coordination, resource centers, volunteer programs, and support programs in rural Cass county (see Appendix M, Community of Care project abstract). This project could serve as a model for future single point of entry, but has limited funding for broader application.

As previously mentioned the State Review Team has examined a one stop model for youth with serious emotional disturbances. Further, ND DHS has reviewed all HCBS programs and services (including waived services) and has moved the Personal Care Program to the Medicaid State Plan to assist in efforts to improve access and options to services.

All of these efforts have been important to improving access to services. Yet these efforts have not been coordinated to build a streamlined system of improved access to services through a One-Stop or SPE.

5. Status of consumer directed services for all funding streams (not just Medicaid) and the use of individual budgets.

ND has several initiatives and programs that support consumer directed services. While not all are specifically implemented for the target populations, they have given ND DHS a good idea of what it wants to accomplish. The Independence Plus Waiver, the Aged and Disabled Self-Directed Care Initiative, the ND Nurse Practices Act, and the Deficit Reduction Act all impact on ND’s ability to support consumer directed services.

Independence Plus. The ND DHS Disability Services Division has received approval of a Medicaid HCBS Waiver under the authority of Section 1915(c) of the *Social Security Act* for a Demonstration Program entitled, ND Self Directed Supports for Adults. This waiver will allow Medicaid beneficiaries to arrange and purchase family and individual supports and related services. The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individuals may remain in the family residence or in their own home. The

ND Self Directed Supports for Adults program offers eligible individuals and their families the opportunity to direct a fixed amount of public resources in a flexible manner that is meaningful and helpful in achieving their personally defined goals. This program is based upon the belief that in order for eligible individuals with disabilities and their families to fully participate in their community, they must define the life they seek and be supported as they direct a mixture of generic and formal supports that will help them achieve their personally defined outcomes.

Aged and Disabled Self Directed Care. ND is in the process of renewing the current Medicaid Waiver for the Aged and Disabled. Within this waiver renewal, the State is planning to add a self directed care service delivery system. If the waiver renewal is approved, self direction would become available to consumers within the next Medicaid waiver.

ND Nurse Practices Act. The current language of the ND Nurse Practices Act requires the supervision and delegation by a nurse to unlicensed assistive persons, so they can provide services, beyond social model services. Individuals providing services supported with Medicaid and State of ND funds must comply with this Act (see Appendix N, ND Nurse Practices Act) which currently limits certain aspects of self directed care. ND DHS staff are working with the Board of Nursing to explore changes in the Act, which will allow individuals to self-direct a portion of their care.

Deficit Reduction Act. The federal Deficit Reduction Act of 2005 offers many opportunities for the Medicaid program and specifically for HCBS. The ND DHS Medical Services Division has assembled a team of staff members who are exploring each provision of the Act. ND DHS is particularly interested in exploring the Money Follows the Person Demonstration grant, the Medicaid Transformation Grants, the Buy-In for Children, and the HCBS provisions. In addition, information is being reviewed related to the Benchmark coverage provisions and ND will be watching how other states use this flexibility to meet the needs of program participants.

Partnerships Program. ND's Partnership program provides case management services for children with serious emotional disturbances. Treatment plans are developed for these children, and a flexible funding pool is used to support movement to, or placement in less restrictive levels of care. Parents are active partners in developing and directing care.

6. Status of developing and implementing a quality management system for long-term supports.

Due to resource constraints, a streamlined Quality Assurance plan has been developed and implemented for the ND HCBS programs. The HCBS Quality Framework was the basis for developing a series of tracking systems and databases. Major components of the data gathering are based on reviews of case management records, provider records and client interviews. The HCBS Team depends heavily on the partnerships that have been developed between various ND DHS divisions and outside entities to assist with information sharing and problem resolution.

However, gathering data through the review process is very staff intensive. Data are gathered through a review of each county every year, half the reviews are completed on-site and the other half are desk audits. Client interviews are conducted in the clients' residence and provider reviews are completed as desk audits. The data are entered into a database which allows for a generation of reports to track trends. The data gathered are rich; however, they are limited in that only a targeted group of clients and programs are evaluated. The data identify the concerns of those who are using Service Payments for the Elderly and Disabled (SPED), Expanded Service Payment for the Elderly and Disabled (ExSPED), Medicaid Waivers, and Medicaid State Plan Personal Care services.

In the mental health system, the children's case management process uses a quality management system along with child welfare and juvenile justice. Each region has a child and family review process where a sample of cases is reviewed annually. Families and children, and those involved in treatment are interviewed, and case files are surveyed. The system is based on quality indicators of family preference, family choice, and individualized care.

The process should be enhanced to allow ND DHS to gather information about the quality of other significant long-term support services for clients such as home health and other privately funded services. The enhancement may require additional authority, technology, process, and staff time.

7. Status of development of information technology that would support transformation of ND's long-term support system.

MMIS. ND has recently received state legislative approval, and will soon sign a contract for the development of a new Medicaid Management Information System (MMIS). ND DHS expects to implement the new MMIS in 2009. This new system will allow for improved efficiency and accuracy in claims payment and will allow the other technology systems to integrate for reporting and analysis purposes.

Regional Office Automation Project (ROAP) is an electronic records keeping and billing system that operates in the Regional Human Services Centers throughout ND. Staff use the CMHC MIS/eCET (electronic clinical expert technology®) software as the information system to support the functions of client demographics, accounts receivable, billing, clinical intakes and assessments, medication management, treatment planning, progress notes and document management, and workflow. The strength of the application comes from its integration and flexibility. After information is entered into the system, it becomes available to each facet of the system in real time. The clinical components and functionality bring extensive clinical content to the desktop, providing for a solid foundation in moving toward fully electronic health records. Clinicians, accounts receivable staff, managers and other authorized staff have immediate access to the records and data, which enables increased efficiency and performance.

EMPI enterprise master index. ND DHS is in the process of developing a Master Client Index. This application will code clients with a unique client ID that will be cross-linked to existing identifiers within each of the Department's respective programs. This identifier will enable client information to be shared across programs in real-time. To accomplish this level of integration, ND DHS is building a client hub infrastructure to support transactions and data requests without having to "hard code" these connections. As this capability does not currently exist, the new architecture will allow for increased flexibility as the supporting programs evolve, as well as provide a more client-focused view into the data systems.

Social Assistance Management Software (SAMS) is used for client assessment, data collection, and case management reviews. SAMS is a web-enabled database for client services under the federal Older American's Act, and home and community-based services. Presently about 48,000 clients are entered into this system. SAMS has excellent data collection processes and provides information for federal reporting requirements. SAMS does not interface with the present MMIS.

8. Status of the rebalancing of funding efforts between institutions and community-based services during the past five (5) years (specify the target populations). Specify if there is a waiting list for the 1915(c) home and community-based waiver program, if applicable.

Status of rebalancing of funding. ND has made some gains in the overall funding for community-based long-term care services (see Figure 1). For example, in the last ND legislative session, HCBS funding increased by 20.8% from the previous biennium. Nursing home funding increased by 7.7% for the same time period. HCBS funding has increased by nearly 45% in the past six years, while nursing home funding has increased by 12.9%.

However, the gap between funding for nursing home care and HCBS services continues to grow. For example, nursing facility allocations grew from approximately \$216.7 million in the 1995-97 biennium to over \$343 million in 2005-07. During this same period HCBS received about \$14.9 million in 1995-97, and grew over 2 ½ times to nearly \$38 million in 2005-07. The nursing home/HCBS gap was just over \$200 million in the 1995-97 biennium, but has grown to over \$305 million during the current biennium. Even though the percentage increase occurs, the gap widens.

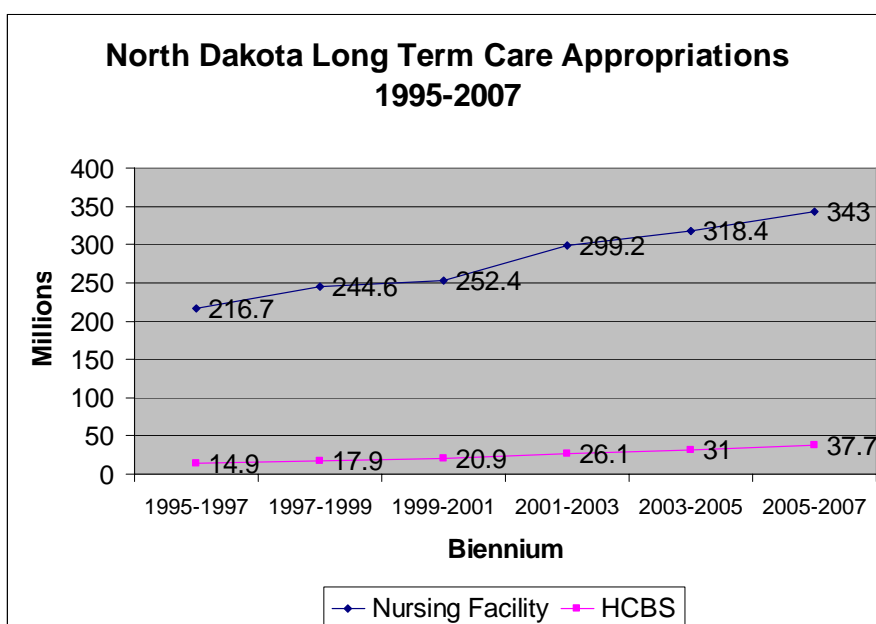


Figure 1. ND long-term care legislative appropriations for nursing facilities and for home and community-based services.

Other information on ND's system funding. ND has conducted numerous studies and reports related to the aging population and people with disabilities. Many of the studies had common findings and recommendations. In 2004, the Senate Workgroup of the ND Disabilities Advocacy Consortium found that the number one barrier to self-direct supports is an inadequate payment system for individual and agency Qualified Service Providers (QSPs).

In 1996, the Task Force on Long-term Care Planning received funding from ND DHS Aging Services for a pilot project to test an expanded case management system. This included a uniform comprehensive assessment. The pilot project tested a case management system design for individuals in need of long-term care services. It would offer assistance to citizens in identifying and securing appropriate, cost effective services in the least restrictive environment, while protecting the rights of individuals to make their own decisions. The Task Force recommended continuation of the Expanded Case Management (ECM) for the 2001-2003

Biennium. Targeted Case Management and pre-admission assessment were included in Senate Bill 2037; however this bill was not approved.

The *Cost Containment Alternatives for ND Medicaid* (2002) found that North Dakotans spend more than most states on institutional services, especially nursing homes and institutions for persons with developmental disabilities. Expenditures are higher partly because ND has more elderly people in its population and the state has more licensed beds per capita than most other states. Elderly ND residents are also more likely to enter nursing homes than are elderly residents of other states. ND also pays higher daily rates to nursing homes than other states. This study identified several important opportunities for savings in restructuring institutional reimbursement but these would require legislative authorization. They also found saving opportunities in expanding managed care, strengthening the managed care enrollment process, and expanding alternatives to nursing home care.

In 2002, the Needs Assessment of Long Term Care was conducted as a result of recommendations made by the ND Department of Health and ND DHS collaborative work group, the Task Force of Long Term Care (1993-2000). Results showed more than one in three non-institutionalized seniors had a disability. The number of seniors in ND with functional limitations, a measure of the level of assistance required for basic activities of living (bathing, eating, walking, and using the toilet), is higher than the national norm and indicates a greater demand for caregivers. The number of senior service facilities is very limited and absent in a significant number of counties in ND. Sixteen of the state's 53 counties lack a hospital or clinic, four counties lack a senior center, and 35 of the counties lack a home health agency.

Status of waiting lists. ND has no waiting lists for individuals who are aged and/or physically disabled and eligible for services under 1915(c).

9. Status of joint initiatives between state housing and service agencies.

Presently, ND DHS has no formal agreements, memoranda of understanding, or substantial joint initiatives between the state housing office and local or state human services agencies. In some cases, there are work groups or task forces that are beginning to examine collaborative goals and outcomes. In other cases, individuals are undertaking work to coordinate client housing needs and other human services smaller. Here is some of the work underway in ND.

NDCES Housing Task Force. The North Dakota Comprehensive Employment Services (NDCES) grant, formally known as the ND Medicaid Infrastructure Grant, funds a statewide housing task force that examines housing issues for people with disabilities and other special needs groups. The mission of the housing task force is to “*Advocate for and promote housing choices for people with disabilities that result in increased employment access.*” The goals of this task force are:

- Goal #1: The Housing Task Force will assure passage of a visitability law in ND during the 2007 legislative session.
- Goal #2: The Housing Task Force will organize advocacy activities/efforts to save the voucher program and to promote voucher flexibility.
- Goal #3: The Housing Task Force will evaluate the effectiveness of public housing programs and identify needed improvements.

- Goal #4: The Housing Task Force will work to increase home ownership opportunities and affordable, accessible rental options for people with disabilities.
- Goal #5: The Housing Task Force will assist the DHS to utilize funds for home renovation as indicated by the Medicaid waiver.
- Goal #6: The Housing Task Force will engage city officials, contractors, homebuilders, landlords and others in education efforts regarding accessibility design and need.

ND Department of Commerce, Division of Community Services. Each year the Division of Community Services prepares an Action Plan to identify various federal and state resources that might be available. This action plan addresses funding of priority housing and non-housing community development needs and objectives in the state. The action plan also describes how funds will be distributed through the Community Development Block Grant (CDBG), HOME, and Emergency Shelter Grants (ESG) programs. The 2005-2009 Action Plan records no specific activities, other than under the affordable housing goals which address the needs of non-homeless special needs persons. The Action Plan states that other state agencies currently administer programs specifically for the elderly, frail elderly, persons with disabilities, developmentally disabled, person with a history of alcohol and drug abuse, and persons with HIV/AIDS. The demand for CDBG and HOME funds for other needs far exceeds the capability to further target the use of funds.

In 2004, the Statewide Housing Needs Assessment was conducted for the ND Housing Finance Agency (NDHFA) and the ND Department of Commerce Division of Community Services. This assessment found that ND lacks sufficient affordable housing, especially for low- and extremely low-income brackets. This assessment recommended that a top priority be elderly housing issues and special attention be given to housing for special needs populations including the frail and physically disabled, mentally disabled, veterans, and moderate-income residents. Fifteen percent of residents 55 years and older in owner-occupied homes and 35 percent of residents 55 years and older in renter-occupied units have cost burdens that exceed 30 percent of their household income.

Olmstead Commission. In 2002, the Olmstead Commission conducted focus groups across the state of ND to collect data on perceptions regarding existing HCBS available to meet the needs of people with disabilities. The need for a full continuum of care service levels in housing, shortage in accessible and affordable housing, and lack of funding for home modifications were some common themes that emerged.

PATH. ND DHS receives Projects for Assistance in Transition from Homelessness (PATH) funding as part of a formula grant program through *Substance Abuse/Mental Health Services Administration (SAMHSA)*. In ND, this funding supports a PATH coordinator in each of the eight regional human service centers. These coordinators are involved in the Continuum of Care, Homelessness Coalition, and the ND Interagency Council on Homelessness.

Governor Hoeven has initiated an Interagency Council, and has joined other states in efforts to eliminate homelessness. The Division of Mental Health and Substance Abuse is the designated member of the Council. ND DHS works with the ND Department of Commerce on a variety of efforts. Staff members are on the Mental Health Planning Council, the Mental Health Transformation Team, the Interagency Council on Homelessness, and the Continuum of Care

committees. Regionally, human services center staff work with housing agencies to support Shelter Plus Care funded housing units.

10. Current level of state interagency and intra-agency collaboration - progress and remaining challenges.

Current progress and successes. ND has done well with inter- and intra-agency collaboration. For example, the ND Indian Affairs Commission has documented what needs to be done to make HCBS work in culturally appropriate manners on the five ND Indian reservations. These cultural competency factors are important guidelines for prospective work in piloting new efforts on the reservations.

The Mental Health Association and the ND DHS Mental Health and Substance Abuse and Aging Services Divisions have collaborated on addressing the unmet needs of older persons who have a mental illness. A multi-agency committee gathered data regarding the training needs of professionals who provide mental health services and a series of training sessions were held statewide for these professionals. Currently the Department is contracting with ND State University to expand training, information and public education regarding mental health and aging.

ND DHS Aging Services Division, the Medical Services Division, and Disability Services Division jointly developed and have collaboratively implemented the state plan for personal care. Previously, personal care was available only through the Aged and Disabled Waiver and through SPED and Ex SPED. While there were unintended consequences of moving the service (e.g. some recipients were required to pay a recipient liability), ND DHS and allied organizations continue to work together to solve the issues that arise.

Challenges. Several challenges face ND DHS in working within and across agencies for the development of home and community-based care and living options. A major challenge is the tight funding levels across state agency budgets. ND's geography and weather impact travel and limit face to face collaboration. Staff use the interactive video conferencing technology when possible, but scheduling and lack of technology access in rural counties makes this problematic. With relatively small departments and divisions, staff are pressed to perform the necessary work to meet state and federal program requirements.

11. List of all Real Choice Systems Change (RCSC) grants awarded to date and progress in and barriers to achieving grant goals.

ND has had few Real Choice grants through CMS. One difficulty is finding time and staff to develop competitive proposals. Another is the balancing that staff must do in handling the daily required work for the state, and timing their work with the announcements of CMS. Here we briefly describe work completed in the past and current grants and projects.

Real Choice Systems Change Grant. In 2001, ND received a RCSC starter grant to apply for grant funding under President Bush's *New Freedom Initiative*. This grant was administered by the ND Olmstead Commission.

In 2002 ND received a RCSC grant that funded initiatives under the direction of the ND Olmstead Commission. A number of local projects were funded during the three-year grant. The local projects included three Living in Place models. Two of the models tested innovative practices in nursing home settings. The other model focused on helping individuals remain in their own homes through an Independent Living Center project called "*No Place Like Home*". A "*Simplified Access to Services Model*" provided the opportunity for the Good Samaritan Society

to reach outside the doors of one of its nursing homes to develop a Community of Care model, developing services to meet the needs of older persons in rural Cass County. This project has continued with the funding coming from the Good Samaritan Society and other grants. The Director of the Aging Services Division and Director of the Medical Services Division continue to serve on the planning committee of the Community of Care project. The Community of Care project director is on the steering committee of the current Real Choice Rebalancing Initiative grant. The Mental Health Association received grant funds to establish the 211 system in ND. The Indian Affairs Commission received funds to develop a cultural congruent model of home and community-based care for American Indians. This project was closely coordinated with the Tribal Liaison and the Aging Services Division of the ND DHS. The Indian Affairs Commissioner also serves as a member of the Rebalancing Initiative steering committee and the results of the cultural model of HCBS have been incorporated into the current Real Choice grant.

Real Choice Systems Change grant- Rebalancing Initiative (RCR). In 2004, ND DHS-Division of Aging Services received a RCR Grant. This grant was aimed at developing a more equitable funding concept for the improvement of HCBS for persons who are aged or have a disability. The grant is midway through its second year. During the first year ND DHS struggled to fill positions. In 2005, ND DHS contracted with the ND Center for Persons with Disabilities (NDCPD) to implement the project activities. NDCPD conducted a statewide of focus group and data gathering meetings, statewide survey, and numerous stakeholder meetings in an effort to create a Single Point of Entry and to determine a more equitable financing strategy for HCBS. A key outcome has been the development of a One-Stop concept for the elderly and/or adults who have a physical disability.

Progress on the RCR Grant has been made. There is general consensus that a one stop system should be implemented. However, there is no definitive plan for development or for funding its operation. The availability of providers and inadequate payment for qualified service providers, especially in the most rural counties, is a major deterrent to implementing a full scale home and community-based system.

12. List of all other pertinent system reform grants awarded to date and progress in and barriers to achieving grant goals.

ND Alzheimer's Disease Demonstration Grant. In 2005, ND DHS Aging Services Division was awarded an Alzheimer's Disease Demonstration Grant from the Administration on Aging. The project was designed to provide training to the medical community to increase early detection of Alzheimer's disease and expand community supports for victims and caregivers. The Dakota Medical Foundation provided \$150,000 of cash match for the project.

Eight regional training sessions on providing supports to individuals with dementia were conducted, with over 200 consumer participants attending. Pre-post test results showed an increase in knowledge and skills by caregivers. Eleven regional training sessions were conducted with primary caregivers (e.g. nurses, county social service workers) regarding early detection and referral. Memory screenings were held in several locations throughout ND, where 45 people were identified at risk for memory problems, 32 for potential depression, and 15 for a combination of memory and depression issues.

ND CES. As previously mentioned, ND received a Medicaid Infrastructure Grant titled, Comprehensive Employment Systems (CES) grant from CMS. This project is designed to develop and implement a true Comprehensive Employment System in ND that will (a) maximize employment for people with disabilities, (b) increase the state's labor force through the inclusion

of people with disabilities, and (c) protect and enhance workers' healthcare, other benefits and needed employment supports. CES staff are presently completing a first year strategic planning process whereby consumer, advocate, employer, state agency and general community input are received and reviewed. This information will be used to develop a comprehensive five year statewide plan.

ND Department of Health Traumatic Brain Injury (TBI) Planning Grant. In collaboration with the UND Center for Rural Health, ND Department of Health conducted an assessment of needs and resources for persons with TBI. Results indicated that persons with TBI and families encountered numerous barriers in accessing and using needed health and social services. A strategic plan was developed that outlined goals and action steps to implement an access, awareness, and intra-agency system to assist ND in moving forward with services for consumers and their families. Grant funding ended in 2005, and funding for implementation has not been obtained.

13. Other barriers that might delay system change efforts.

ND realizes that identifying barriers now may not truly represent future barriers. However, if past experience is useful for future prediction, we anticipate the following barriers.

Legislatively allowable funding. ND DHS's work will rely upon legislative authority for funding and spending. ND has traditionally been fiscally conservative, often taking considerable time to reflect on and then enact change. This reflective approach may delay some activities that fall under the purview of the ND legislature. Staff will need to work closely with legislators on education of the issues.

Turf issues. Some agencies and providers may be reticent to change, and may engage in activity to stop or slow system change efforts. This may be the result of perceptions where the agencies feel the state may impinge on their turf. However, these programs and staff have continued to attend meetings and have been involved in ongoing productive discussions about differences.

Nurse Practices Act. In some cases, individual choice may require provision of services by direct service providers that might not be allowed under ND's current *Nurse Practices Act*. For example, if an individual requires medication administration, and chooses a service provider who is not a nurse for medication administration, there would be concern about the availability of reimbursement and potential liabilities. Fortunately, ND DHS personnel and the ND Board of Nursing are working to address these issues.

Qualified Service Providers (QSPs). There is presently a concern about the availability of QSPs who may be needed for the provision of more integrated HCBS in ND's future. Barriers include not only the availability of direct service workers in a state that is very rural and has one of the nation's lowest unemployment rates, but also the issue of level of reimbursement for the providers, and the lack of skills to provide services. These barriers issues may actually inhibit provision of some community-based services in the most rural counties.

Technology. The current electronic payment system that is in place for QSPs is antiquated and slow. Errors occur easily which impact the process for paying providers. These errors may cause undo hardship for private QSPs who are dependent on the source of income. Also the current system used for financial eligibility determination does not allow for a streamlined process that incorporates functional eligibility. It is often a frustrating process for consumers who fill out numerous applications for state and federal funded programs to see if they qualify.

Lack of community living options. Assisted living is one of the fastest growing types of senior living care. However, the services provided vary and often the cost is not affordable, making this option prohibitive to many low-income seniors. The majority of assisted living facilities in ND have high rates and are generally only used by private pay individuals.

ND Adult Family Foster Care services have been decreasing due to providers not seeking Adult Family Foster Care licensure. Unfortunately, reimbursement rates for providers are often an issue, and many providers will not serve those individuals with more significant needs. They have a difficult time meeting costs with the reimbursement rates, and many of the current providers are “aging out” themselves.

ND is experiencing a high demand for supervised living arrangements for individuals who do not need skilled nursing care. There are few funding options and those available require extensive ‘patching’ of a variety of funding sources making options cumbersome and often unrealistic. There are also young adults transitioning into the adult system who need supervision but do not need institutional care. There are few options for this population who often have mental illness issues requiring ongoing care and support. Another population requiring supported community living is those individuals transitioning out of high intensity treatment settings. Often they have psychiatric issues that require some level of supervision prior to independent living. There are few options for this group as well.

Most people wish to remain in their own home for as long as possible or at least in their own community. However, there is a lack of affordable and accessible housing. The majority of ND homes would not be adequate for a person with a disability without at least some modification. Many rural residents are not able to choose where to live because there is a lack of housing and service options. Often, rural residents are left to choose between an inadequate housing situation or institutional care. Further, transportation services are often lacking in sparsely settled communities, creating one more barrier.

Community awareness of HCBS options. Currently there are over 80 Skilled Nursing Facilities in ND’s 53 counties. This makes Skilled Nursing Facility care the most prominent choice of care in many communities. Consumers and families are not consistently informed about HCBS options. Often the information they receive about HCBS is very scattered and fragmented. They may also have limited time to research options for care especially in health care crisis situations. This lack of consistent information causes confusion and frustration (Appendix H, Focus Group summary).

14. Overcoming barriers to hiring state and contractual staff to work on a system transformation grant.

Working through the state process for hiring staff and developing contracts for work can sometimes be cumbersome. At times, developing a position announcement, receiving approval for the position, advertising, interviewing, and hiring an individual can take three to six months. Further, the contract bid, review and award process can take even longer. These delays can sometimes cost projects valuable time.

ND will use several strategies to facilitate the actual start of work on this project. First, ND DHS anticipates shuffling staff amongst divisions to facilitate hiring for the project. As mentioned previously, the ND DHS infrastructure was recently reorganized by the Executive Director, thus making staffing arrangements more flexible. Second, ND DHS can advertise for new positions even prior to award, with the notation that they would be filled only upon funding. ND DHS will do the same for out-sourced contracts. Thus, ND DHS anticipates having a pool of

candidates for the new positions on or near the start date of the award, and a pool of bid applicants for contracts at the same time.

15. Document any reductions or increases in Medicaid state plan options, home and community-based programs, and in covered populations during the past five (5) years for individuals with disabilities in need of long-term supports.

During the 2001-2003 biennium and due to Department projected shortfalls, two state funded programs (i.e. SPED and Expanded SPED) were frozen and new enrollments were limited. During this time period, unduplicated counts of persons were also reduced. During the 2003-2005 biennium, the two state funded programs became more accessible to persons not found eligible for a Medicaid Waiver. However, some of the restrictions and limitations implemented in 2001-03 continue to apply. For example, non-medical transportation was eliminated as a service option under SPED and Expanded SPED. During the 2003 Legislative Session, ND DHS was authorized to move Personal Care Services to the Medicaid State Plan.

16. ND's history and ability to implement components-to-scale.

ND has had success in moving initiatives from small, pilot tests to full scale statewide implementation. Two particular initiatives are worthy of comment here.

Children's System of Care for Mental Health. ND DHS implemented a coordinated system for mental health care for children with serious emotional disturbances. ND was awarded a system of care grant through SAMHSA in 1994 to develop a system of care for children with serious emotional disturbances. The premise behind this effort is full parent involvement, cross system collaboration, and least restrictive care focusing on community-based services. This six year grant was the impetus for the development of a care management system for children in ND. There was great collaboration between social services, juvenile services, and human services and private providers statewide. The grant initially began in the Minot, Fargo, and Bismarck regions. In year five, the grant expanded statewide. The legislature supported this effort which has sustained the program after grant funding ended. This model has continued in multiple systems. Parent-to-Parent support also receives continued funding under this effort.

Single plan of care. Under the ND Partnership grant, ND DHS developed a format for documenting a coordinated plan of care across a variety of programs and agencies. Originally, the document was developed in paper format. Now the document is electronic, and is implemented statewide. The Single Plan of Care (SPOC) is a web based treatment plan which can be viewed by the agencies involved with a child and their family with proper confidentiality safeguards. This has taken ND a step closer to truly having one plan for a child versus multiple plans from multiple agencies. The system supports a team-based planning process with focus on family preferences and culture. Currently, county social services, and partnerships through the human service centers, as well as the Division of Juvenile Services use this plan.

17. Laws and regulations that have been implemented to further systems change efforts.

ND has passed legislation to support the state's gradual movement toward systems change that is client-centered and oriented toward individual choice and home living options. From a review of this section and the more detailed history of *ND's Benchmarks in the Development of Services and Supports for Individuals with Long-term Care and Services Needs* (see Appendix O), ND's intent to promote community-based systems change is evident.

In 1997, the legislature passed a law regarding the voluntary treatment of children with serious emotional disturbances. This legislation provides an avenue for parents with a child in the Medicaid program needing out-of-home treatment to access that treatment without relinquishing custody of the child.

In 2003, ND passed Senate Bill (SB) 2194 which created a Medical Assistance Buy-in program, and directed Personal Care to be available as a Medicaid optional service. It allowed Medicaid recipients who live in their own homes access to personal care services. In 2005, House Bill (HB) 1148 amended SB 2194 and directed ND DHS to apply for a waiver to allow self directed care and allow recipients to hire unlicensed care givers.

In 2003, the ND legislature passed SB 2330 which states:

“Any aged or disabled individual who is eligible for home and community-based living must be allowed to choose, from among all service options available, the type of service that best meets that individual's needs. To the extent permitted by any applicable waiver, the individual's medical assistance funds must follow the individual for whichever service option the individual selects, not to exceed the cost of the service. The department of human services shall apply for the waivers and grants necessary to implement this section under existing or future federal legislation.”

In 2005, HB 1190 and HB 1191 effectively placed a moratorium on the expansion of basic care bed capacities and long-term care bed capacities in ND. Essentially, the expansion of basic care or long-term care beds in nursing homes is prohibited except in limited circumstances. In addition, HB 1012 directed ND DHS to develop a plan to transfer individuals at the ND Developmental Center to community placements, with the transfers beginning as soon as possible.

Part 2: Current Level of Transformation

Based on the SRA, ND believes that **Mid-range Transformation** best describes the state's level of readiness for movement toward a statewide, comprehensive system for persons with chronic care needs, individuals with mental illness, and individuals with either condition who are further negatively impacted by socioeconomic status and/or psychosocial needs. As noted in the SRA, ND has positioned itself well for movement to a more integrated system of care for the target populations. We have not had the luxury of large funding supports, or total agreement with the concept. However, the work on the RCR Project, the reorganization efforts at ND DHS, and past legislative progress will allow North Dakota to move forward at a reasonable pace. While ND has chosen mid-range, the state has some areas that are in the preliminary stages of development. However, ND has chosen the highest level that applies to ND's situation. The following presents the state's rationale for the choice of mid-range.

Narrative summary for choice of mid-range transformation

Reform has occurred across multiple agencies. As noted in the SRA, ND has undergone reform in several agencies. First, the ND DHS has undergone recent organizational change. The administrative structure has been changed to be more cognizant of, and more responsive to, community-based alternatives for care. ND's State Review team has brought together multiple agencies (e.g., education, human services, justice) to address support and care systems for individuals with mental illness. This team's work has set an excellent example of the types of future efforts that can occur in ND. The RCR grant has brought together multiple agency representatives to set the stage of implementation of a state one-stop system for the chosen populations.

Reform has occurred for multiple populations. ND has developed initiatives in aging (RCR grant), disabilities (Alzheimer's Disease Demonstration grant and Olmstead Commission work), and long-term care (legislative limits to institutional beds). ND's legislative action to limit the increase in institutional placements for both adults and children shows support for change. ND's work with individuals with developmental disabilities and with those with Alzheimer's places us in a superb position for further change. ND has a regional system of case management and community services for adults with developmental disabilities and individuals with serious emotional disturbance. In addition, the statewide information and training efforts in Alzheimer's have linked us with families and care providers who are poised for future change. Unfortunately these systems are not in place for the general aging population, nor those with physical disabilities.

Commitment and progress toward sustainability. ND's commitment for sustainability for systems change is evident. The governor has given his whole-hearted support for movement toward more inclusive, integrated, and consumer-driven services for the chosen populations. Legislative initiatives over the past 5 years have positioned ND to transform current policy and practices into a better system.

Limited innovation. Perhaps ND's greatest barrier in past work, and a great challenge for future efforts, will be the ability to make innovative change. Legislative changes have been pieced over several years, and each, while important, is generally insufficient for whole-scale innovation and change. The most telling example is the recent efforts in working for a new management information system for the ND Medicaid office. Initially, the legislature appropriated \$29 million for the effort. However, the price tag for system development, in order

to become efficient and effective, has grown to over \$50 million. This has caused great consternation, although each dollar is easily justifiable for the level of innovation and change required to run a smooth and consumer-oriented system.

Further, state funding levels have left it to piece together smaller one, two, or three year grant programs aimed at relatively narrow populations. ND has been successful in pulling some programs into more long-term, sustainable systems (e.g., Partnerships Program), but the effort is often doubled due to the constant start up and wind down of grant programs. In some cases, constituents are suspect of the state's commitment due to the continual introduction of the newest grant program. This infrastructure and system change grant will serve as the impetus for effective future change.

Part 3: Transformation Goals

North Dakota's Goals for System Transformation

ND has chosen four goals to address in this project. This selection process was done by numerous ND DHS staff at a large inter-departmental meeting. Staff accessed and referred to documents described in the SRA. The selected goals (numbered as presented in the RFP) are:

Goal 1: Improved access to long-term supports through a ND one-stop model;

Goal 4: Use of information technology to support ND systems change;

Goal 5: Better funding management systems that promote community living; and

Goal 6: Coordination of long-term support systems with housing.

These goals and the accompanying objectives and activities have been uniquely refined to address specific state needs. They are linked in a logical and necessary fashion. For example, gaining access to information and assistance for long-term supports is a necessary first step in planning. ND plans to use and adapt existing technology to assure that a one-stop model functions properly. Gaining information about costs, and possible other funding options is important in self-directed care. Finally, one must have access to and information about available housing, especially housing that promotes community living options. Access, flexible funding options and housing are huge issues in a rural state like ND, and the use of technology and other existing resources makes sense for the selection of these goals.

For each goal, a rationale provided for choosing the goal, a narrative for how ND will be successful in implementing the goal is given, a description of objectives is presented, and preliminary strategies to meet the objectives, anticipated accomplishments, and evaluation strategies are outlined. These are preliminary and may change during the strategic planning process. However, they have been used to develop initial budgets for the project.

GOAL 1. IMPROVED ACCESS TO LONG-TERM SUPPORT SERVICES: DEVELOPMENT OF ONE-STOP SYSTEM

Rationale for Choosing Goal 1

Long-term care has traditionally been viewed to target the elderly. There is increasing recognition, however, that such services are also needed by younger persons with disabilities, including individuals with severe mental illness. ND DHS seeks a framework for a generic system for providing long-term care services. 'Generic' refers to a programmatic approach designed to serve all persons regardless of age, diagnosis, or condition, whose ability to function in daily life without substantial assistance from others is severely limited.

ND has done a significant amount of work in designing a one-stop system. The ND State Review Team's work with NDCPD to develop a one-stop model for children with mental illness, and NDCPD's work on the RCR grant has set the basic parameters for a one-stop or SPE model. Recent RCR grant focus groups conducted with ND seniors, persons with disabilities, their families, and providers identified common problems regarding continuum of care services. They identified problems such as unclear information about services that people receive and the lack of basic, comprehensive information about the services available. A common theme was the need for a SPE or a streamlined, simplified service system for improved access to comprehensive and timely information about long-term support services. Consumers also identified the need for

a knowledgeable “go to person” available to assist consumers and families to navigate the long-term support system.

ND clearly needs improved access to information about long-term support services. Accessing information about services is a natural first step in transforming ND’s system of long-term care supports. Since ND has no formal one-stop system, we have chosen goal one for implementation.

Selected Objectives

As required by the RFP, ND will address all three objectives which are: *Objective 1– Provide awareness, information and assistance; Objective 2- Streamline the multiple eligibility processes; and Objective 3- Target individuals who are at imminent risk for admission to an institution.*

Why ND will be Successful with Goal 1

ND will use the STG to create a new one-stop system to improve access to services. ND has the work of two groups, the ND State Review Team for individuals with mental illness, and the ND RCR Grant for persons who are aged and/or have disabilities. Essentially, ND has the features of two models for the target populations. However, the state needs to mesh these two models, determine the best short and long-term strategies to implement the one-stops, and then test them through pilot project efforts.

Strategies to Achieve the Goal 1 Objectives

Objective 1– Provide Awareness, Information and Assistance. ND will use a stakeholder consultation process to synthesize the information from the two previous conceptual models. Staff will work with the RCR grant steering committee, the ND State Review Team, and agency personnel to determine the salient components of the final ND one-stop model. Staff will incorporate features of other current systems such as the 211 phone system, and the Senior Info Line when possible. Once the model features are finalized, staff will test the model in one large and one small region. At least one of the regions will include a ND Indian Reservation.

A rigorous data collection and evaluation system will be established for these pilot projects. A consultant evaluator will be hired to guide those efforts. Using these pilot data, the staff will make necessary adjustments to the model, the features, and the processes. The revised ND one-stop system will then be implemented across the state. A strategic planning and implementation task force will be established to guide the development and initial operation of the one-stops.

Objective 2 - Streamline the Multiple Eligibility Processes. ND’s intent for this objective is to assure that ND’s intake, assessment and eligibility personnel are cross-trained to provide smooth, consistent procedures that ease the process for constituents. ND STG staff will implement several activities to accomplish this objective. First, the one-stop task force will work closely with the MMIS development team to assure that the relevant features of the state’s MMIS are integrated into the one-stop system. Next, the task force will assess the current intake, assessment and eligibility determination procedures to identify what works, and what needs improvement. Once the relevant, common features are identified, a set of training outcomes will be delineated, and a training curriculum will be developed. Regional trainers will be taught to cross-train staff in common, and unique features of the eligibility processes. Essentially, staff will be able to perform all relevant procedures, easing the process for applicants and their families.

Objective 3 - Target Individuals Who Are at Imminent Risk for Admission to an Institution. In ND, those individuals who are imminent risk for admission to an institutional setting are those with more than minimal basic care needs who are leaving short or long hospital stays, or are in crisis situations. In order to assure that these most at risk individuals know about, have access to, and are referred to more community living options, ND STG staff will implement activities to train discharge personnel, provide widespread advertising, and gather data on the impact of this work.

ND STG staff will educate primary discharge personnel, referral source staff, and families about the types, costs, and availability of community-based long-term care options. These will include hospital discharge planners; family, geriatric and critical care physicians; community nursing staff; hospital and other medical social workers; family members and others as identified by the medical and human services communities. Information developed for the one-stop system will be revised into concise, clear materials for dissemination. For example, a sample triage process could be developed to assist discharge staff in making appropriate recommendations for community-based services. A project website will contain both the training materials and the reference materials for these personnel. Project staff will travel throughout ND to conduct group and individualized education sessions.

A widespread marketing and advertising campaign will accompany this training effort. This must be done to combat the current perceptions of medical staff, families, and constituents that the only available long-term care option in ND is the nursing home. Newspaper, television, radio and other advertising media will be used to convey the message across the state.

Anticipated Accomplishments

At the end of the five-year grant, ND will have an effective and efficient one-stop system. We believe the system will have been in operation for a minimum of 2 to 2 ½ years, and the state will have data regarding its impact on long-term care options for persons with chronic care needs, those with mental illness, and individuals with chronic care needs or mental illness who are also adversely impacted by socio-economic status and/or unemployment. ND will have an effective, efficient, visible and trusted one-stop system that will allow individuals in the target population, their families, and ND professionals to access information and assistance about the full range of long-term care options and services. This one-stop will be available not only through technology such as the internet and by telephone but will also offer a place, with well trained options counselors for the target population, their families, and the general public.

Anticipated evaluation questions. ND will use all three suggested evaluation questions and accompanying outcome indicators to document the accomplishments of the ND one-stop model. These questions are:

- Is the one-stop system developed effective?
- Is the one-stop that has been developed efficient?
- Is the one-stop visible, accessible, and approached with trust?

Anticipated measurement strategies. The evaluation target data points and possible methods are outlined in the following table. An evaluation contractor will be hired to refine the questions and indicators required for this grant, to develop rigorous procedures to data collection and analysis, and to provide interpretations and recommendations for formative and summative processes for the project. The evaluation will only progress once approval is received from CMS.

Evaluation Question	Target Data Point(s)	Anticipated Method(s)
	<ul style="list-style-type: none"> • Individuals served (pre, post, and trends) 	<ul style="list-style-type: none"> • One-stop system tracking of contacts on a monthly and annual basis
<i>Question 1: Is the ND one-stop system effective?</i>	<ul style="list-style-type: none"> • Institutional placements for target populations • Stakeholder satisfaction with one-stop system 	<ul style="list-style-type: none"> • State placement data (ND DHS records system) on nursing home placements • One-stop Consumer satisfaction questionnaires
<i>Question 2: Is the ND one-stop system efficient?</i>	<ul style="list-style-type: none"> • Timeline for eligibility determination • Consumer satisfaction 	<ul style="list-style-type: none"> • State Medicaid data system analysis • One-stop consumer satisfaction questionnaires
<i>Question 3: Is the ND one-stop visible, accessible, and approached with trust?</i>	<ul style="list-style-type: none"> • One-stop user demographics • Cultural competency of system 	<ul style="list-style-type: none"> • One-stop tracking system logs • One-stop consumer questionnaires

GOAL 2. (RFP Goal 4) TRANSFORMATION OF INFORMATION TECHNOLOGY TO SUPPORT SYSTEMS CHANGE

Rationale for Choosing Goal 2

ND is in the initial stages of designing and developing a new MMIS for Medicaid services. The state legislature appropriated approximately \$29 million to accomplish this task. However, due to demands for systems, limited vendors, and a significant industry change in technology platforms, the cost of these systems has increased significantly. After negotiations, the system will be over \$50 million, and should be ready for implementation in early 2009. The newer systems allow Medicaid programs to be more efficient and effective and help ensure seamless health care system operations; however, the initial development costs are significant.

Unfortunately, the high cost of the base system will not include several useful consumer-oriented pieces. Specifically, the scopes of work and costs proposals were prepared well before the SPE started taking shape in ND. Therefore, no interfaces are included in the current cost of development. A SPE that integrates the assessment piece with the eventual payment system is critical. For example, if a consumer is authorized for \$2,000 of services, and is approved to self-direct their own care, there needs to be integration to the payment side. This integration will

“transport” electronically the assessment and authorization information to the payment system. As services are used and billed, the balance of the authorization would be charged, and the consumer could use a web-based search process to check the status of his/her account. Due to the priority of the MMIS, this integration would be implemented after the final rollout of the system. Therefore, ND would expect the rollout in calendar year 2010 or 2011.

Selected Objectives

ND selects three objectives for this goal: *Objective 1 - Design IT applications that will support program practices and processes that are individual-centered and enable persons to direct their own services; Objective 2 - Improve client access to long-term care services through the use of integrated IT system(s); and Objective 3 - Use integrated systems to monitor the quality of services rendered.*

Why ND will be Successful with Goal 2

ND has the people and the tools to accomplish this goal with the anticipated funding. The state technology personnel are highly skilled and can assist in making this technology transformation. ND has the local and regional connections to assure correct implementation. Further ND DHS staff are committed to using consumer data to guide continued improvement in programs for the future.

ND's previous work on the RCR grant, and ND DHS's many consumer-oriented initiatives have placed ND in prime position to accomplish this goal. Extensive internal and external analysis of systems, processes and infrastructure have been completed in preparation for ND's MMIS has provided valuable information about what ND will have, and what ND needs. ND DHS commitment to consumer-oriented information access and choice highlights the dedication to see this through to fruition.

Strategies to Achieve the Goal 2 Objectives

The implementation of goal 2 is highly dependent, and closely linked to the work for the one-stop model. In the one-stops, staff and consumers must have access to continually updated information on services, fees, budget parameters, and regional variations. Thus, the one-stop material will be an active and changing source that assures all have the most complete and accurate material for distribution. The technology staff will work to (a) keep the one-stop database up to date; (b) link the one-stop data to widely dispersed computerized information kiosks; and (c) provide evaluation data from consumers and families so that ND DHS staff can continually improve services.

Objective 1 - Design IT applications that will support program practices and processes that are individual-centered and enable persons to direct their own services. The major activity for this objective will be to develop a technology solution to support consumer-directed care by allowing access to services and budget items under the ND Medicaid system. This will require a significant collaboration between ND STG staff (especially the IT staff member) and the MMIS contractor and ND Medicaid staff. The intent is to give consumers access to the total menu of long-term services, state and regionalized support providers, and anticipated costs for the services. Once these consumers have an understanding of the costs, they will be able to make informed choices for their care.

A significant piece of the work on this objective will be working not only on the content, but on the accessibility components of the IT. The information must be available to families and

to consumers with a variety of disabilities. Thus, voice, large print, and perhaps even pictorial representations of the information may need to be designed. Accessibility experts will be consulted for these tasks.

Objective 2 - Improve client access to long-term care services through the use of integrated IT systems. Access to state information data is complicated by ND's geography. Although ND has eight regional human service centers, many long-term care programs are accessed through private agencies or county offices, which are usually not in the same building or even in the same community as the human service centers. Therefore, ND needs to use a wider distributive method to disseminate the information. ND will use computerized information kiosks spread throughout the state to assist in client access to long-term care services information.

ND STG staff will develop partnerships with local hospitals, long-term care programs, human service centers, county social services offices, *Older Americans Act* service providers and other entities to place and maintain long-term care information kiosks. STG Staff will work to co-support these kiosks, and improving chances for sustainability past the term of grant funding. An information dissemination task force will help ND STG staff identify potential partners, suggest possible locations in each of the 53 counties, and work to establish a statewide presence. IT staff will establish systems to keep the information database (essentially the same database used for the one-stop model) up to date, and readily available.

Objective 3 - Use integrated systems to monitor the quality of services rendered. ND needs an integrated quality management system to monitor service quality across the state. While ND's new MMIS system will have internal evaluation and monitoring mechanisms, there is no funding available to develop a fully integrated consumer input and quality assessment system. STG staff and IT personnel will work with the MMIS contractor to develop a system to link consumer feedback on service quality into the overall system. ND anticipates some type of linkage between the one-stop data collection procedures, the information kiosks, and web-based consumer surveys with the MMIS. External data collected by these various mechanisms would be ported to Medicaid program staff on a periodically. Various reports would be generated to link with the MMIS system and assist staff in measuring quality. Along with IT services, project staff will need the assistance of the project evaluator, and technical support from CMS staff to successfully accomplish this goal.

Anticipated Accomplishments

ND will have necessary technology systems, information disseminations methods, and technology linkages between its state MMIS and local technology systems for better consumer information access, thereby allowing increased consumer direction and choice.

Anticipated evaluation questions. ND will use two of the suggested evaluation questions and accompanying outcome indicators to document the accomplishments of this goal. These questions are:

- Whether, and to what degree, has the integrated IT system contributed to enhancing client/beneficiary access?
- How have integrated systems been used to evaluate levels of quality improvement?

Anticipated measurement strategies. The following table shows the initial plan for assessing ND's progress and summative accomplishments for Goal 2. While this table is only an

outline, more specifically refined data targets and methodologies will be developed through the strategic planning process, and through consultation with the project evaluation consultant. The evaluation will only progress once approval is received from CMS.

Evaluation Question	Target Data Point(s)	Anticipated Method(s)
<i>Question 1: Whether, and to what degree, has the integrated IT system contributed to enhancing client/beneficiary access?</i>	<ul style="list-style-type: none"> • Number of people who access kiosks • Number of contacts at one-stop sites • Number of hits on various database components 	<ul style="list-style-type: none"> • Electronic means for counting, recording and reporting system entries
<i>Question 2: How have integrated systems been used to evaluate levels of quality improvement?</i>	<ul style="list-style-type: none"> • Consumer satisfaction surveys on services received • State Medicaid staff interviews and reports on usefulness of system for quality management 	<ul style="list-style-type: none"> • Web-based satisfaction questionnaires • Staff interviews

GOAL 3 (RFP Goal 5): CREATION OF A SYSTEM THAT MORE EFFECTIVELY MANAGES THE FUNDING FOR LONG-TERM SUPPORTS THAT PROMOTE COMMUNITY LIVING OPTIONS

ND intends to address two objectives under this goal. The purpose of these objectives is to assure that, for an individual and for the state, the options that support community living are appropriately funded.

Rationale for Choosing Goal 3

ND's community-based living options are presently supported by both state and federal funding. Together, these funding sources create a complex and sometimes inefficient system for supporting individuals. Currently, ND's aging and disabled population is "carved out" of the state managed care plan. Most of these individuals are in the target population of chronic care needs, and thus may not receive the type and level of service required for community supports. Further, the provider payment rates are varied, making payment, tracking, monitoring, and reimbursement procedures cumbersome and unnecessarily complex. A capitated managed care plan that includes the aging and disabled population might remediate these problems.

ND DHS is working closely with two provider groups to implement Program for All-Inclusive Care of the Elderly (PACE). These capitated programs for the frail elderly mirror a SPE model as they provide all Medicare and Medicaid Services, in addition to applicable social services determined as necessary by a multidisciplinary team. With ND being such a rural state, PACE implementation may pose additional considerations such as adequate enrollment,

transportation expenses or availability of personnel. The efforts of this grant and specifically this goal will assist ND in achieving successful PACE implementation in ND.

Selected Objectives

ND selects two objectives for this goal, *Objective 1 – Develop and implement more effective payment methodologies*; and *Objective 2 – Target high cost individuals and services or geographic areas with high unmet needs*.

Why ND will be Successful with Goal 3

ND DHS is well positioned to move quickly on this goal and the accompanying objectives. As presented in the SRA, the 2005 ND legislature promoted the use of long-term care insurance as a non-asset in determining eligibility under Medicaid. Essentially, if an individual purchases long-term care insurance prior to application, the assets of the individual must be disregarded when determining medical assistance eligibility. This bill clearly promotes the use of privately funded options in conjunction with public funding for long-term care.

The second objective will target the availability, skills, and compensation of QSPs for the target populations. There are disincentives for QSPs to work in ND, particularly in more rural areas.

Strategies to Achieve the Goal 3 Objectives

Objective 1 - Develop and implement more effective payment methodologies. Under this objective STG staff will do two major activities. First, staff will market and promote the use of public-private packages to fund community-based care. A marketing firm will be contracted to work with staff, state agency personnel, and consumer representatives to assure that the marketing efforts are affordable, accurate, and make the desired impact.

Second, STG staff will work on capitated managed care rates, and promote their use in Medicaid. Staff will contract with an actuarial firm in years 2 – 5 of the project to analyze the financial data and impacts, and then set the capitated rates at reasonable and competitive levels. Further, STG staff will work with ND DHS staff to assure that the current managed care includes the aged and disabled populations, rather than carving them out as is the present case.

Objective 2 – Target high cost individuals and services or geographic areas with high unmet needs. For this objective, STG staff will use strategies to reengineer the financing structure for rural QSPs, and will develop or enhance mechanisms to enroll and retain competent QSPs, especially in the most rural counties. STG staff will organize a QSP task force, combining consumers with members of other committees on QSPs. The task force will work with the actuarial contractor in developing appropriate reimbursement rates to remove at least one disincentive. The task force will work with STG staff to enhance the current ND QSP curriculum now available through Lake Region State College, develop a marketing and recruitment plan with a contracted marketing firm, and work closely with QSPs to determine effective support strategies to retain them. The QSP task force will work on this issue during the strategic planning process, the implementation of the strategic plan activities, and the evaluation of the impact of implementation.

Anticipated Accomplishments

At the end of the five year project, ND residents will have increased choice and control over services and individual budgets for long-term care services. They will make use of public-

private partnerships in funding long-term care. Individuals will also have QSPs who are paid appropriately for their services, utilizing differentiated rates that are reliable and valid based on market and geography.

Anticipated evaluation questions. ND will use a single evaluation question and accompanying outcome indicators to document the accomplishments Goal 3. The question is:

- How has the ND Medicaid budget been impacted by the implementation of this goal?

Anticipated measurement strategies. The following table shows the initial plan for assessing ND's progress and summative accomplishments for Goal 3 (RFP Goal 5). While this table is only an outline, more specifically refined data targets and methodologies will be developed through the strategic planning process, and through consultation with the project evaluator. The evaluation will only progress once approval is received from CMS.

Evaluation Question	Target Data Point(s)	Anticipated Method(s)
<i>Question 1: How has the ND Medicaid budget been impacted by the implementation of this goal?</i>	<ul style="list-style-type: none"> • ND Medicaid budget, including state and federal share • ND Medicaid recipients' participation in public/private funded strategies for housing and long-term supports 	<ul style="list-style-type: none"> • State office budget review • Medicaid recipient survey

GOAL 4 (RFP Goal 6). LONG-TERM SUPPORTS COORDINATED WITH AFFORDABLE AND ACCESSIBLE HOUSING

Rationale for Choosing Goal 4

The RFP for this project states that "The purpose of this goal is to create, or build upon, a system to remove barriers that prevent Medicaid-eligible individuals with disabilities from residing in the community and in the housing arrangement of their choice." As displayed in the SRA, ND has no formal agreement or arrangements to coordinate Medicaid services, long-term care services and affordable and accessible housing for the target populations. Unfortunately, state resources are limited in actual construction or provision of additional and specialized housing for these individuals. However, STG staff work collaboratively with state, regional, and local housing associations and community housing rehabilitation programs to expand appropriate community housing options.

Selected Objectives

ND selects two objectives for this goal, *Objective 1 – Improve the coordination of long-term supports within affordable housing, and Objective 2 – Increase access to affordable housing with long-term supports.*

Why ND will be Successful with Goal 4

ND is a relatively small (populous) state. Local and state agency staff are familiar with each other. In fact, many serve on the same or similar committees throughout the state and face similar issues. Because they work so closely together, they can quickly reach the crux of the problems and begin to identify solutions. Staffs' personal connections will be valuable here.

Second, ND will use significant consumer involvement to address this goal. A large portion of the interagency task force on long-term care and housing will be individuals who represent or are part of the targeted populations. Finally, ND will formalize agreements with housing agency partners to assure a coordinated effort on this goal.

Strategies to Achieve the Goal 4 Objectives

Objective 1 - Improve the coordination of long-term supports within affordable housing. First, STG staff will establish an interagency task force on coordinated long-term care and housing. Task force members will focus on this goal throughout the strategic planning process, and during implementation of strategic planning activities in subsequent years. One of the first tasks will likely be the development of a memorandum of understanding between state and local long-term support agencies and housing authorities.

One major problem identified in the SRA is the availability of housing for persons with mental illness who need some care and supervision, but who have less than intense or critical needs for hospitalization or institutional care. Several years ago ND had Intermediate Care Facilities in Mental Illness (ICF-MI) to address this housing problem. However, they are not currently available. The task force will examine the feasibility of developing and funding community-based ICF-MIs for ND.

Medicaid systems transformation projects suggest that embedded service coordination and case management physically within community-based housing is a successful and promising practice. The task force will examine measures to implement this idea.

During the strategic planning process, task force members and STG staff will examine electronic and other methods to evaluate the impact of improved coordination of long-term supports and housing.

Objective 2 - Increase access to affordable housing with long-term supports. A key strategy for this objective is identified in the RFP, and embraced by the ND staff. Involving consumers, stakeholders and private-public partners in the planning, implementation, and evaluation of the project is crucial. Again, ND will establish an interagency task force on coordinated long-term care and housing. Members will come from disability, aging, chronic care needs, mental health, and other target population advocacy groups. Other members will include representatives from state and local housing agencies (both publicly and privately funded), the county social services programs, the ND DHS Medical Services Division, the ND DHS Aging Services Division, the ND Governor's office and other relevant agencies as determined by the Principal Investigator and the Project Director.

Another strategy for this objective will be the dissemination of a state housing registry through ND's one-stop system. STG staff will include the housing registry in the one-stop system, and provide ongoing updates to assure that consumers and their families have accurate, reliable information about community housing options.

Anticipated Accomplishments

At the end of the five year grant, ND will have more affordable and accessible housing for the target populations. ND will have an effective information and dissemination network to assure all constituents have the necessary information to link long-term service options with housing.

Anticipated evaluation questions. ND will use all three suggested evaluation questions and accompanying outcome indicators to document the accomplishments of Goal 4. These questions are:

- Has the capacity of the affordable and accessible housing increased?
- Has the capacity of affordable and accessible housing that can accommodate persons with disabilities of any age and provide long-term supports increased?
- Has access to affordable and accessible housing that coordinates and/or provides long-term supports improved?

Anticipated measurement strategies. The following table shows the initial plan for assessing ND's progress and summative accomplishments for Goal 4 – (*RFP Goal 6*). While this table is only an outline, more specifically refined data targets and methodologies will be developed through the strategic planning process, and through consultation with the project evaluator. The evaluation will only progress once approval is received from CMS.

Evaluation Question	Target Data Point(s)	Anticipated Method(s)
<i>Question 1: Has the capacity of the affordable and accessible housing increased?</i>	<ul style="list-style-type: none">• Numbers of community housing options available for target populations	<ul style="list-style-type: none">• State housing registry
<i>Question 2: Has the capacity of affordable and accessible housing that can accommodate persons with disabilities of any age and provide long-term supports increased?</i>	<ul style="list-style-type: none">• Numbers of housing options with specialized services (e.g., MI intermediate care) for target populations	<ul style="list-style-type: none">• State housing registry
<i>Q 3: Has access to affordable and accessible housing that coordinates and/or provides long-term supports improved?</i>	<ul style="list-style-type: none">• Number of community housing settings which have on-site case managers or service coordinators	<ul style="list-style-type: none">• State housing registry

Part 4: Strategic Plan

ND DHS will develop a comprehensive strategic plan that will identify a process and plan for a true systems transformation in ND. ND DHS will contract with outside professionals who will have specialized knowledge, education, skills and experience to develop a comprehensive strategic plan. Due to the timeline of the systems transformations grant RFP, ND DHS will develop a pre-planning guideline for the strategic planning processes prior to the official award announcement. The ND DHS feels it is extremely critical to develop guidelines which will ensure that at the time of the award announcement that ND is ready to proceed with the required 9-month strategic planning process.

Due to procurement laws for state agencies, ND DHS will need to develop an RFP to hire vendors for strategic planning. The first step in the strategic planning process will be for the Program procurement officer to form an RFP team in late July 2006.

The RFP will contain clear instructions to vendors, identification of the scope of work, identification of the specifications, contractual terms and conditions, concise evaluation criteria, opening of proposals, evaluation process, and notice of intent. The second step of developing ND's strategic plan is to draft the RFP processes which will be completed in mid-August 2006 and will contain the following information;

1. Clear instructions to vendors, which include:
 - a. Submission requirements (when, where, how many);
 - b. Schedule of key dates and events;
 - c. Proposal format (technical/proposed cost);
 - d. Registration requirements;
 - e. Ground rules for solicitation, evaluation and negotiation;
 - f. North Dakota preference law; and
 - g. Protest procedures.
2. Clear identification of the scope of work, which includes:
 - a. Identifying what is to be achieved, rather than how to achieve;
 - b. Describing the problem and asking for a solution;
 - c. Identifying what solutions are not acceptable and will not be entertained;
 - d. Providing the background for the proposal;
 - e. Describing the tasks and completion schedule;
 - f. Listing the deliverables (what they are going to provide/produce):
 - (1) Services;
 - (2) Reports;
 - (3) Equipment;
 - (4) Systems; and
 - (5) Hardware and Software.
 - g. Clear, measurable acceptance criteria and performance measures:
 - (1) Qualitative; and
 - (2) Quantitative.
3. Clear identification of the specifications:
 - a. Specification types:

- (1) Performance;
 - (2) Design;
 - (3) Combination of performance and design;
 - (4) Brand name or equivalent; and
 - (5) Brand specific.
 - b. Description of desired functionality or performance standards;
 - c. Any mandatory requirements;
 - d. Avoid "optional" language:
 - (1) Use "must" or "shall"; and
 - (2) Avoid "may" or "should".
 - e. Minimum qualification requirements:
 - (1) Licenses;
 - (2) Certifications;
 - (3) Service areas;
 - (4) Years of experience; and
 - (5) Track record.
- 4. Contractual terms and conditions:
 - a. RFP will include the terms and conditions that will apply to the contract;
 - b. Term, extension and renewal provisions; and
 - c. Indemnification and insurance.
- 5. Concise evaluation criteria:
 - a. RFP will state the relative importance of price and other factors/sub-factors;
 - b. If not in the RFP, it does not exist;
 - c. Cost must be a consideration;
 - d. Direct link between evaluation criteria and scope of work;
 - e. Criteria weight or value; and
 - f. Minimum qualification requirements.
- 6. Opening of proposals:
 - a. Proposals should be opened so as to avoid disclosure of contents to competing vendors during the process of negotiation; and
 - b. All proposals received are exempt records under N.D.C.C. § 44-04-17.1(5) until an award is made.
- 7. Evaluation process:
 - a. Instructions to evaluation committee:
 - 1) Explain time demands;
 - 2) Explain handling of information;
 - 3) Explain attempt to influence; and
 - 4) No ethical conflicts of interest.
 - b. Program Procurement Officer reviews for responsiveness, then:
 - 1) Members do the initial proposal scoring;
 - 2) If necessary, members hold discussions with vendors for their best and final proposal and then re-score proposals;

- 3) Tabulate final scores;
- 4) Issue notice of intent; and
- 5) If necessary, negotiate.

8. Notice of Intent:

- a. Send to all vendors:
 - (1) List of vendors that submitted proposals;
 - (2) Announce the successful vendor; and
 - (3) Vendors right to appeal.
- b. Instructions to successful vendor:
 - (1) Vendors cannot proceed until the contract is signed; and
 - (2) Insurance/bonds must be verified prior to signing the contract.

When these processes are completed, the third step of developing the strategic plan is to conduct solicitation to potential vendors. The timeline for this step will occur during the month of September, 2006. The following steps will be utilized;

1. Issue the RFP and provide notice to potential vendors (September 1, 2006);
2. Conduct a pre-proposal conference or conference call (September 8, 2006);
3. Answer questions and provide clarification (On-going – September 15, 2006);
4. Issue an RFP amendment, if needed;
5. Receive and open proposals (deadline September 27, 2006 – 5:00 p.m.);
6. Evaluate, discuss and determine the best and final proposal (September 28-30, 2006); and
7. Issue the notice of intent to award (September 30, 2006).

When ND DHS issues the notice of intent to the most qualified vendor, the fourth step of the strategic plan will be to begin contract negotiations and this will occur October 1-15, 2006. The contract for strategic planning between ND DHS and potential vendor will be ready for signature on October 15, 2006 pending the award notification of the Systems Transformation Grant.

The strategic planning processes will bring together a wide-variety of collaborating partners to develop a comprehensive strategic plan which ensure true systems transformation in ND. Potential collaborating organizations and partners may include:

Potential Strategic Planning Partners

Office of the Governor	North Dakota Department of Human Services (all Divisions)
AARP North Dakota	County Social Service Organizations
North Dakota Disabilities Advocacy Consortium	North Dakota Long Term Care Association
Community Health and Eldercare, St. Alexius Medical Center	Community of Care; Cass County
ND Real Choice Rebalancing Grant	ND Protection and Advocacy Project
Legislative Council	State Senators and Representatives
Governor's Committee on Aging	Indian Affairs Commission

ND Comprehensive Employment Systems	North Dakota Olmstead Commission
ND Centers for Independent Living	Consumers and Family members
ND DHS / Tribal Liaison & Program Civil Rights Officer	ND DHS Regional Aging Services Program Administrators-RASPA
North Dakota Mental Health Association	North Dakota Association for Disabled
Fair Housing of the Dakotas	North Dakota Human Rights Coalition
Older American's Act Providers	Easter Seals Goodwill
ND Hospital Association	North Dakota Association of Home Care
ND Medical Association	Nat'l Association of Mental Illness (NAMI)
ND DHS Extended Care Coordinators	ND Department of Commerce, Community Services Division

The following diagram shows the anticipated strategic plan process that will be used by ND DHS and the Strategic Planning Contractor.

Strategic Planning Model

